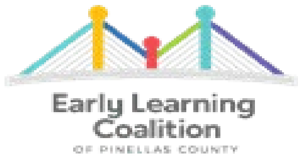


# MONTHLY ADJUSTMENT REQUEST FORM

**Provider Site Name**________________________________ **Provider ID#**_________________________

**Adjustment Month and Year (MM/YYYY)** ___________________________

**Please print so information is legible.**

| Child's First Name | Child's Last Name | Date of Birth | Reason for Adjustment |
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Please do not put multiple months on one form. **<u>This form needs to be uploaded to the Monthly Adjustment Request folder.</u>** This form is used to notify the Coalition staff of issues related to provider reimbursement. Examples of reasons that an adjustment may be requested are: child is missing from the OEL Provider Portal attendance roster, child's birthdate is incorrect which affects the care level (INF, TOD, 2YR, etc.), child's schedule is incorrect (FT, PT, etc.), child has NS for no schedule, start date is incorrect, term date is incorrect, child is duplicated on the attendance roster, or RJOA Form and supporting documentation were not attached to the 4th absence at the time the attendance was recorded and submitted. Per rule, the Coalition must be notified of adjustments within 60 days of the receipt of reimbursement by the provider. <u>Reminder: Due to the fiscal year ending as of June 30, May and June adjustment requests must be submitted no later than July 25.</u>

Name of Person Completing this Form ___________________________________Date:____________

Revised 02-2022